MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Wol + Med, Ed. Wolski, M.D. 2436 IH-35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7815-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 American Casualty Co. /Gallagher Bassett PO Box 23812 Tuson AZ 85734	Date of Injury: Employer's Name: Thyssenkrupp Elevator Corp. Insurance Carrier's No.: 011508010245WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/26/02	11/26/02	99080-73	$2.25	$.2.25
12/3/02	12/4/02	97545 x 4	$102.40	$102.40
12/3/02	12/12/02	97546 x 22	$408.80	$408.80
			Total Due:	$513.45

PART III: REQUESTOR'S POSITION SUMMARY

7/14/03: "…The carrier has failed to make reimbursement as per the TWCC MFG. The carrier's version of the TWCC-62 does not give adequate information, and does not show PEC's, and descriptions in accordance with the TWCC-62. The carrier's use of this type of EOB makes disputing payment reductions difficult…We submitted our request for reconsideration stating these issues; however, the carrier failed to respond as per TWCC rule…"

PART IV: RESPONDENT'S POSITION SUMMARY

NO RESPONSE RECEIVED FROM RESPONDENT

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Codes, 99080-73, 97545-WH-AP and 87546-WH-AP, for DOS 11/26/02 through 12/12/02, were all denied with "00663 TED According to state fee schedule guidelines." According to 133.304 (c), the respondent did not submit sufficient explanation for reduction or denial of payment to requestor, therefore reimbursement according to the MAR is recommended.
- The requestor submitted sufficient documentation showing their effort in trying to obtain the reconsideration EOB's according to Rule 133.307 (e)(2)(B). Documentation of services rendered supports reimbursement according to MFG/MGR (II)(E). Recommended reimbursement per MAR.
- 99080-73 - DOS 11/26/02, MAR $15.00 (–previously received $12.75 x 1 DOS =) $2.25 due.
  97545-WH-AP, DOS 12/3/02 – 12/12/02 ($102.40– (paid $51.20=$25.60 x 4 DOS =) $102.40 due.
  97546-WH-AP, DOS 12/3/02 – 12/12/02, ($64.00- (paid $51.20=$12.60 x 22 DOS =) $408.80 due.
  TOTAL DUE: $513.45

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $513.45. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Name	4/15/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____